Dear Out-of-State Provider,

To enroll as an out-of-state Medi-Cal provider, the following information is required:
(Please attach this form to your original claim and *mail* in.)

Provider/Facility Name: _____

Ambulance- circle one:	**** circle one:**
Air Ground	**MD DO**

ATTENTION: _____
(If you have a hospital or clinic name)

Service Address: _____

City, State, ZIP: _____

"Pay to" Address, if different (include city, state and ZIP):

_____

ATTENTION: _____
(If you have a second name for your facility or billing company)

****License Number: _____**

****License issue Date: _____ Exp Date: _____**
(DD/MM/YY) (DD/MM/YY)
****Social Security Number: _____**

Federal Tax ID Number: _____

Business Phone: (____) _____

Please attach this letter to your claim form with the requested billing information and send to:

EDS
OUT-OF-STATE UNIT
P.O. BOX 15507
SACRAMENTO, CA 95852-1507
(916) 636-1960

Please disregard this letter if you have already submitted an enrollment form.
****Individual Practitioners only**

For online Medi-Cal provider manuals, access www.medi-cal.ca.gov.